Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Peter G Foox

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-13-2683-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Resubmitted for reconsideration"

Amount in Dispute: $368.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier is in the process of re-auditing this bill for payment. Carrier will supplement its response with payment documentation. If the re-audit resolves all issues, this matter will be appropriate for dismissal."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2012	Physician Services	$368.00	$214.91

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 18 – Procedure code was invalid on the date of service

Issues

1. Did the requestor support payment was not made on disputed services.
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 15 – "Claim/service lacks information which is needed for adjudication." Review of the submitted documentation finds the following;
    a. Complete 1500 claim form completed within Division guidelines
    b. Medical records identifying procedures performed

   The carrier's denial is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)…."
    - Procedure code 99213, service date June 29, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.97. The practice expense (PE) RVU of 1.03 multiplied by the PE GPCI of 0.912 is 0.93936. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum of 1.96599 is multiplied by the Division conversion factor of $54.86 for a MAR of $107.85.
    - Procedure code 97035, service date June 29, 2012, represents a professional service with reimbursement determined per §134.203(c). The total MAR for this service is $18.97
    - Procedure code 97140, service date June 29, 2012, represents a professional service with reimbursement determined per §134.203(c). The total MAR for both units of service is $88.09
    - Per Medicare policy, procedure code 97530, service date June 29, 2012, may not be reported with procedure code 97140 billed on this same claim without a modifier and supporting documentation to identify a separate and distinct procedure was performed. No modifier or documentation was found. Separate payment cannot be recommended.
    - Procedure code 97265 was not valid on the date of service. The carrier's denial as, 18 – "Procedure code was invalid on date of service is supported."
3. The total allowable reimbursement for the services in dispute is $214.91. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $214.91. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 214.91.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $214.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 24, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.